Proposed Synopsis for Ph.D. Pre-registration seminar

on

A Study of Anxiety, Stress and Depression among Couples Affected by Recurrent Miscarriage in Ranchi District

By

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1.0 Introduction

1.1 State of the Art

The aim of this study is to investigate the stress, anxiety and depression states of Mothers affected by recurrent miscarriages. This study adopted a comparative Approach to compare stress, anxiety and depression among married couples (male and female) in Ranchi district. Studies on recurrent miscarriages have been conducted in various parts of India and other countries. It doesn't take days for the body to recover from a miscarriage, but the mind does take time to recover. However, the psychological impact of this loss is often underestimated. Women's personal feelings about these benefits may vary and may be influenced by race, age, religion or belief, but most women experience symptoms of stress, anxiety and depression. Because miscarriages are rare, doctors are accustomed to dealing with this diagnosis. However, data collection, diagnosis, and management of clinical procedures may reduce the incidence of mental illness in these women. Researchers have proven that most stress, anxiety and depression are caused by miscarriage. This study focused on the effects of stress, anxiety, and depression on recurrent miscarriages and compared the stress, anxiety, and depression of mothers (male and female) of parents affected by miscarriage.

1.2 Conceptual framework of the start

1.3 Anxiety

Hart, J. (2013) Anxiety is an emotional state characterized by physiological changes such as anxiety, worry, and blood pressure. Anxiety can be defined as the somatic symptoms of irritability and anxiety, as well as the anticipation of future harm or suffering.

Physical Signs of Anxiety

- Heart palpitations
- Dry mouth and difficulty swallowing
- Dizziness or lightheadedness
- Legs weak, " jelly like"
- Stomach churning and feeling pain
- Increased shakiness, especially in hands and above the arms
- Tingling and numbing sensation
- Feeling hot, sweaty and flush

- Muscles shortness of breath
- Chest bandage.

Psychological Symptoms of Anxiety

- Feeling scared and nervous
- Felling like you are lose your mind
- Felling like you are going to have a heart attack
- Feeling like you are out of control
- You will feel anxious

Behavioral Symptoms of Anxiety

- Excuses to avoid doing something
- Avoid shopping only during quiet times or in small stores to avoid crowds
- Avoiding place or situations where you are stressed
- Avoiding conversations or activities
- Avoid talking to other
- Avoid going out alone or asking someone to go with you
- alcohol or drugs using other substance such as

1.4 Stress

Lazarus, R.S. and Folkman, S. (1984). Stress is part of our lives. It is impossible to avoid stress. Mild to moderate stress is good for you. Anxiety is the feeling of stress and anxiety. Anxiety is a type of mental illness. Some stress can be beneficial because it can increase motivation, athletic performance, and environmental impact. But excessive stress can increase the risk of mental health problems such as stroke, heart disease, ulcers and depression, and can also increase the risk of pre-existing chronic diseases. Stress can be short-term or long-term. Both can cause a variety of symptoms, but chronic stress can harm the body and long-term health.

Common Stress symptoms are:

- Changes in mood
- Clammy or sweaty palms
- Decreased sex drive
- Diarrhea

- Difficulty sleeping
- Digestive problems
- Dizziness
- Feeling anxious
- Frequent sickness
- Grinding teeth
- Headaches
- Low energy
- Muscle tension, especially in the neck and shoulders
- Physical aches and pains
- Racing heartbeat
- Trembling

1.5 Depression

Depression is a negative emotion that causes depression and dissatisfaction (APA 2015). Feelings such as self-confidence are low and unpleasant. Depressive states are medically associated with mental disorders such as bipolar disorder, unipolar disorder, major depressive disorder (MDD), seasonal affective disorder, and dysthymia. The state of depression is often accompanied by decreased activity, energy, sleep, appetite disturbances, motivation and participation in the world. Most people will experience depression, which is treated by poor problem solving, at least once in their lives when they experience stress in life, such as a relationship, financial loss, or conflict. Some people who experience this condition often feel hopeless about their lives and may even try to end their lives. A depressed person may feel depressed or sad, but the sadness is often less noticeable than a lack of interest in activities they once enjoyed. Anxiety can be an important emotion, sadness is not. Changes in mood are accompanied by negative thoughts, the future looks bleak, people see themselves as negative and unhappy, and situations seem very difficult or surprising or disappointing. Negative interpretations of the self and the world that are characteristic of melancholy may appear irrational or distorted to others and appear to focus on the negative, ignoring positive or neutral options. As depression progresses, physical weakness and facial changes may occur. Sometimes people sleep more than usual, but waking up at night or in the morning can disrupt sleep.

Common Depressive symptoms are:

- Reduced concentration and attention
- Reduced self- esteem and self-confidence
- Ideas of guilt and unworthiness
- Bleak and pessimistic view of the future
- Ideas or acts of self- harm or suicide
- Feelings of hopelessness
- Disturbed sleep and appetite

1.6 Miscarriage

Miscarriage is defined as the termination of pregnancy in the first or second trimester (Lerner, 2003). Doctors and medical researchers often use the term abortion when referring to miscarriage (Scher & Dix, 2005). Most doctors and nurses now consider pregnancy loss before the 20th week of pregnancy as miscarriage, rather than termination at the 28th week (APA, 1994; Child, 2006; Lerner, 2003). For the purposes of this study, "miscarriage" will be operationalized to refer to the loss of pregnancy prior to the 20th gestational week (American Psychiatric Association; Child; Lerner; Scher & Dix).This change is attributed to innovations in science and technology that increase babies chances of survival (Scher and Dix, 2005).However, data also show that miscarriages occur from 22 weeks into pregnancy (Serrano & Lima, 2006), 24 weeks into pregnancy (Raj & Regan, 2006), and even up to 28 weeks into pregnancy (Geller, Kerns, & Klier). ; Geller, Clear and Neugebauer, 2002). For the purposes of this study, the term "miscarriage" will refer to miscarriages occurring before the 20th week of pregnancy (American Psychiatric Association; Child; Lerner; Scher & Dix).

Recurrent miscarriage

The loss of three or more consecutive pregnancies prior to the 20th week of gestation is the most commonly accepted definition of recurrent miscarriage (Child, 2006; Lerner, 2003; Scher & Dix, 2005).

Early miscarriage

A miscarriage that occurs before 12 weeks gestation is considered an early miscarriage (Douglas & Sussman, 2000).

Late miscarriage

A miscarriage that occurs between 12 and 20 weeks pregnancy is considered a late miscarriage. During miscarriages at this stage of pregnancy are referred to as second trimester losses, or fetal deaths (Douglas & Sussman, 2000).

Stillbirth

Fetal death that occurs after at least 20th weeks of gestation is considered to be stillbirths (Cohen, 2005). Stillbirth occurs in 1% of pregnancies (Douglas &Sussman,2000).

Dilation and curettage (d & c)

A d & c is a medical procedure used to open the cervix and scrape the uterus to remove an embryo or fetus (Cohen, 2005; Lerner, 2003). This procedure is sometimes referred to as a d & e, which stands for dilation and evacuation (Lerner).

Perinatal period

The period prior to delivery as well as the first month following the birth is called the perinatal period (Douglas &Sussman, 2000).

Perinatal loss

Perinatal loss is the loss of fetus or child from the time of conception until the first month following birth, including: miscarriage, ectopic pregnancy, stillbirth, neonatal death, and the death of a twin during pregnancy, labor, or birth, and the relinquishment of a child for adoption (Callister, 2006; Douglas &Sussman, 2000).

Review of Literature

Parvin. R., et al. (2022) Conducted a study on the effect of miscarriage on women's health. The study was a cross-sectional study, which was done within six months at the Natun Vuqta Malithia of the Sailkupa Upazila under Jhenaidah District who was affected by miscarriage. A total number of 100 women with a history of miscarriage were included in this study. The data was collected from the field through direct interviews and the method of data collection was case study method by using a well-developed semi-structured questionnaire. Among the 100 of respondents 74% of respondent's first delivery was happened between the age 13-20 years and 33% of respondents faced the problem during intercourse and among them 41% suffered from abdomen pain, 91% respondents faced problems after miscarriage, 31% respondents faced problem at first conception and 48% respondents have a live children

more than one conception. 26% of respondents lost their every pregnancy to miscarriage and 81% faced problem to continue pregnancy after miscarriage, 66% could not identify the causes of miscarriage, 72% faced long- term physical problem after her miscarriage and the higher 18% were suffering from uterine problems, 48% were suffering from complication like infection after miscarriage. 80% respondents faced heavy bleeding, 67% were suffering from dysmenorrheal. 31% respondents faced problem to attend in social program without having children due to miscarriage which affects on respondents psychological condition.

Assylzhan. I., et al. (2023) Conducted a study depression, anxiety and stress kazakhstani women with recurrent pregnancy loss; a case - control study. This was a case–control study involving 70 women with confirmed recurrent pregnancy loss and 78 ethnically matched control women. Depression, anxiety, and stress were evaluated using the Depression Anxiety Stress Scales (DASS)-21 instruments. Linear regression and correlation analysis were used in assessing the association of recurrent pregnancy loss with symptoms of depression, anxiety, and stress, after adjusting for key covariates. Results: Women with recurrent pregnancy loss were found to have significantly higher mean scores for depression ($p < 0.001$), anxiety ($p < 0.001$), and stress ($p < 0.001$) symptoms. Mild to moderate stress and mild to moderate and severe to extreme depression and anxiety symptoms were more frequent in the recurrent pregnancy loss group than in the control group. Regression analysis demonstrated that recurrent pregnancy loss was the only significant variable associated with anxiety, depression, and stress symptoms. Conclusion: The results of this study suggest that women with recurrent pregnancy loss are more likely to experience heightened symptoms of depression, anxiety, and stress. Proper psychological counseling is recommended for women with recurrent pregnancy loss, as well as their spouses.

Chen. S., et al. (2019) Conducted a study on stress, anxiety and depression perceived by couples with recurrent miscarriages. Snowball sampling and Convenience sampling were used respectively to recruit 80 couples without and 78 couples with recurrent miscarriage from October 2014 to July 2015. Five structured questionnaires including The Perceived Stress Scale, State-Anxiety Inventory, Interpersonal Support Evaluation List, Pittsburgh Sleep Quality Index and Edinburgh Depression Scale were administered. Women who experienced recurrent miscarriage perceived significantly higher levels of stress, depressive, anxiety and symptoms than their husbands. Women in the recurrent miscarriages group reported significantly greater depressive symptoms than women in the other group. A stepwise multiple regression analysis indicated key predictors of depressive symptoms among

women of childbearing age, accounting for 62.9% of the variance, were stress, anxiety, social support and history of recurrent miscarriage.

Kolte. A.M., et al. (2015) Conducted a study on depression and emotional stress is highly prevalent among women with recurrent pregnancy loss. In this cross-sectional study, we compared the prevalence of stress and depression among 301 women with recurrent pregnancy loss and 1813 women attempting to conceive naturally. Recurrent pregnancy losing the patients was enrolled from 2010 to 2013 and the comparison group from 2011 to 2014. Recurrent pregnancy loss patients completed an online questionnaire before their first consultation at the Danish recurrent pregnancy loss Unit. In addition, we included data from a comparison group of 1813 women who participated in the Soon Parents Study. Cohen's Perceived Stress Scale (PSS) was used to measure stress and the Major Depression Index (MDI) was used to assess symptoms of depression. Relevant demographic data were also retrieved. The recurrent pregnancy loss patients, 26 (8.6%) had a score on the MDI corresponding to moderate/severe depression, as did 40 (2.2%) of the women in Soon Parents Study (adjusted odds ratio (OR) 5.53 (95% confidence interval (CI): 2.09; 14.61). A high stress level, defined as ≥19 on the PSS scale, was reported by 124 (41.2%) of the patients and 420 (23.2%) in the comparison group (adjusted OR 1.59 (95% CI 1.03; 2.44).

Qu. J., et al. (2021) Conducted a study a prospective, longitudinal study was employed. A convenience sample of depression, Anxiety, and social support across pregnancy in women with a history of recurrent miscarriage: A prospective study 66 pregnant women with a history of recurrent miscarriage completed the consider at their 6–12, 20–24 and 32–36 gestational weeks. The prevalence of anxiety at early, middle and late pregnancy was 47.6%, 36.1% and 32.5%, respectively, whereas that of depression was 38%, 34.3% and 31.3%, respectively. Social support scores increased from early pregnancy to middle pregnancy then remained in late pregnancy. There were correlations among depression, anxiety and social support across pregnancy.

He. L. et al (2019) Conducted on study prevalence of depression and anxiety in women with recurrent pregnancy loss and the associated risk factors. 1138 non-pregnant women aged 20–40 years old who attempted to conceive were invited to complete a questionnaire, including basic information, Self-Rating Anxiety Scale (SAS) and Self-Rating Depression Scale (SDS). 782 recurrent pregnancy loss women, 218 women with one pregnancy loss and 138 women with no history of pregnancy loss were included in this study. We found that both recurrent pregnancy loss patients and women with one pregnancy loss had significantly higher SDS and SAS scores than the control group ($P = 0.006$, 0.003).

Furthermore, in recurrent pregnancy loss patients, those with lower education level (lower than university), lower household income (< 10,000 yuan) and history of induced abortion had significantly higher levels of depression and anxiety. Women with multiple pregnancy losses (≥ 3) and no live birth had significantly higher SDS scores. Women who had been married for 3 years or more had a significantly higher SAS score. Logistic regression revealed that lower education level (lower than university) was an independent risk factor for depression (adjusted OR = 1.75, 95% CI 1.10–2.77, $P = 0.018$) and anxiety (adjusted OR = 1.80, 95% CI 1.04–3.13, $P = 0.037$), and women with three or more pregnancy losses had increased odds of depression than those with two pregnancy losses (adjusted OR = 1.82, 95% CI 1.15–2.88, $P = 0.012$).

Thapar. A.K (1992) Conducted on study psychological sequelae of miscarriage: a controlled study using the general health questionnaire and the hospital anxiety and depression scale. The total number of 60 consecutive women admitted to a Swansea hospital with a miscarriage was compared with 62 consecutive women who attended an antenatal clinic at the same hospital, using the hospital anxiety and depression scale and 28-item general health questionnaire. These were completed both at initial contact and six- weeks later. Women who had had a miscarriage were found to be significantly more anxious and scored higher on the sub-scale for severe depression than the pregnant women, both at the initial assessment and six-weeks later. At the six-week assessment, more somatic symptoms were also experienced by the group who had a miscarriage. This study highlights the psychological disturbance associated with miscarriage. The primary health care team and hospital staff needs to consider this when organizing follow up - for women who have had a miscarriage.

Bhagat. S. (2024) Conducted on the relationship between psychological stress and Recurrent pregnancy loss prospective study. A total number of 40 couples who had experienced at least two consecutive miscarriages were recruited by means of convenience sampling. The inclusion criteria are miscarriage that which is 2 or more in number and spontaneous. The socio-demographic details of patients were assessed using a semi-structured questionnaire. The other related history which includes parity, pregnancy week duration following duration of marriage, abortions and other bad obstetric history were also inquired. The history of previous pregnancy complications was also recorded. Emotional distress such as depressive cognition, anxiety features, stresses and sleep disturbances among the couples were analyzed using HAM-A and HAM-D scales. Females experience more perceived stress than their counterparts. Male and female significantly differ on the

dimensions of appraisal support (t (78) = 10.62, p < 0.01, belonging support (t (78) = 10.70, p < 0.01, esteem support (t (78) = 9.64, p < 0.01 and tangible support (t (78) = 10.56, p < 0.01). Observation from the table states that the mean score of female ($\bar{X}$ = 41.25) on anxiety is high than male ($\bar{X}$ = 23.48). Further stated that the mean score of female ($\bar{X}$ = 18.98) on depression is high than males ($\bar{X}$ = .75).those couples having high appraisal support and belonging support are low on stress. Those couples have high depression and stress.

Kagami. M. (2012) Conducted on study psychological adjustment and psychosocial stress among Japanese couples with a history of the recurrent pregnancy loss. The study included 76 couples who had recurrent pregnancy loss and visited the outpatient clinic of a tertiary hospital. They completed self-administered questionnaires that assessed recurrent pregnancy loss associated stress, quality of their marital relationship (Quality Marriage Index, QMI), depression (Beck Depression Index) and anxiety (State-Trait Anxiety Inventory). Women showed significantly higher levels of depression, anxiety and recurrent pregnancy loss associated personal and social stress compared with men. Although there were no differences in QMI scores and recurrent pregnancy loss associated marital stress between men and women, women with a low perception of marital relationship quality (low QMI) had significantly higher levels of anxiety and depression compared with women with a moderate or high QMI. In different between depression and anxiety scores did not differ according to the quality of the marital relationship among men. Of 76 couples, 26 men (34%) and 45 women (59%) who had considered professional mental health consultations regarding their stat recurrent pregnancy loss us but had not yet initiated the process were more anxious and depressed than 48 men and 24 women, respectively, who had never considered such consultation.

Kolte, A. M., (2019) Conducted on study Pregnancy outcomes after recurrent pregnancy loss Ð a longitudinal cohort study on stress and depression. Prospective cohort study with online questionnaires using the Major Depression Inventory (MDI) and Cohen's Stress Scale (PSS) at referral and after one year. The total number of 301 women with recurrent pregnancy loss completed the first questionnaire. One year after referral, 185 women (61%) completed a follow-up questionnaire. The total number score above the threshold for major depression on the MDI at referral was not a predictor for outcome in the first pregnancy after referral; OR (95% CI) for live birth 1.71 (0.66; 4.44), nor was increasing scores on the PSS: OR 0.98 (95% CI 0.94; 1.02). At follow-up, women who had achieved a pregnancy which ended with the birth of a live born child had significantly lower scores on

both the MDI: 13.45 (11.05) versus 11.04 (11.07), difference -2.41 (95% CI -4.60; -0.23) and the PSS: mean 17.69 (7.59) versus 13.03 (6.83), difference -4.66 (95% CI -6.04; -3.28), respectively.

Tavoli, Z. (2018) Conducted on study quality of life and psychological distress in women with recurrent miscarriages a comparative study. This was a comparative study of quality of life among women with and without recurrent miscarriages. Cases were selected from patients with complain of recurrent miscarriages and comparison groups were selected from women attending two teaching hospitals for annual screening. Quality of life (QOL) was measured using the Short Form Survey (SF-36 items).The Hospital Anxiety and Depression Scale (HADS) were used to measure anxiety and depression. Comparison was made between the two groups using the independent samples chi-square and t-test. In all 105 women with recurrent miscarriages and 105 healthy women were studied. The socio-demographic status for both groups was similar. Women with recurrent miscarriage showed a significantly higher degree of psychological distress mean (SD) anxiety score was 10.6 (2.3) vs. 9.1 (2.2), $P < 0.0001$, mean (SD) and depression score was: 11.0 (2.3) vs. 9.5 (1.9), $P < 0.0001$).

2.0 Problem to be investigated

The problem which has been taken for investigation is "A Study of Anxiety, Stress and Depression among Couples Affected by Recurrent Miscarriage in Ranchi District"

3.0 Objectives of the investigation and motivation

The following objectives have been formulated for the present study:

1. To measure the level of Anxiety, Stress and Depression among Gender (Male and Female).
2. To examine the level of Anxiety, Stress and Depression among Socioeconomic status (High and low).
3. To examine the level of Anxiety, Stress and Depression among Ethnicity (Sarna and Christian).
4. To examine the relationship between Anxiety, Stress and Depression.

3.1. Motivation of the research

I have noticed that some people experience poor interpersonal relationship and communication skills due to repeated miscarriages. Later, I realized that if these symptoms

are not recognized and treated in time, people May also experience symptoms of stress anxiety and Depression. A serious mental illness will emerge in future. Then, I decided to do research in this field.

4.0 Research Hypotheses

The following hypotheses have been formulated for the present study:

1. There will be significant difference between Anxiety, Stress and Depression among Gender (Male and female) affected by Recurrent Miscarriage.
2. There will be significant difference between Anxiety, Stress and Depression among Socioeconomic status (High and low) affected by Recurrent Miscarriage.
3. There will be no significant difference between Anxiety Stress and Depression among Ethnicity (Sarna and Christian) affected by Recurrent Miscarriage.
4. Anxiety, Stress and Depression will be positively correlated with each other.

5.0 Research Design and Methodology

5.1 The Sample

The purposive sampling technique will be select 160 couples having recurrent miscarriage problems and data will be collected from a Sadar Hospital Ranchi District. The stratification will be based on:

Gender = 2 (Male and Female)

Ethnicity = 2 (Sarna and Christian)

Socio-economic Status =2 (High and Low)

Table no-1

Sample design

Gender	**Male**				**Female**				**Total**
Ethnicity	**Sarna 40**		**Christian 40**		**Sarna 40**		**Christian 40**		**160**
Socio-economic Status	**High 20**	**Low 20**	**High 20**	**Low 20**	**High 20**	**Low** 20	**High 20**	**Low 20**	**160**
Total	**80**				**80**				**160**

Dependent variables

a) Anxiety

b) Stress

c) Depression

Independent variables

a) Gender

b) Ethnicity

c) Socio-economic states

Inclusion criteria

- That couple who are suffering from more than two recurrent miscarriage within 5 years
- Both male and female have availability
- Age range from 18 to 35 years
- Couples who can read and comprehend Hindi and local language.
- Couples who are belong to saran and Christian cast

Exclusion criteria

- That couple who are not suffer from more than two recurrent miscarriage with 5 years
- Unmarried couple
- Participants having history of psychiatric illness
- Age range below 18 and above 35
- Family history suggestive of psychiatric illness
- Participants having major/severe physical illness.

6.0 Sources of data and tools to be used for collection of data

Data will be taken from Sadar hospital Ranchi District and the following tools will be used for data collection

1. Participant Screening Form
2. Socio-Demographic Data Sheet
3. Hamilton Anxiety Rating Scale (HAM-A)
4. Perceived Stress Scale (PSS)
5. Beck depression inventory (BDI-D)

6.1 Tools description

1. Participant Screening Form

It is a semi-structured Performa designed specifically for this study. It contains impotence information about how long you have been pregnant, how many babies you have had, and how many miscarriages you have.

2. Socio Demographic and Clinical Data Sheet

This is a semi-structured Performa specially designed for this study. It contains information about socio-demographic variables like age, sex, cast, education, residential area, socio-economic status. Certain clinical variables are also included such as history of substance use, seizure, head injury, mental retardation, family history of psychiatric illness and any other physical or psychiatric illness.

3. Hamilton Anxiety Rating Scale (HAM-S)

Hamilton Anxiety Rating Scale was developed by Hamilton (1959). This test is suitable for adults, teenagers and children and takes approximately ten to fifteen minutes to administer. This scale is consisting of 14 items, each defined by symptoms, measures stress and anxiety. Although the HAM-A is still widely used as an outcome measure in clinical trials, it is sometimes criticized for its poor ability to discriminate between anxiety and depression, as well as stress and somatic stress. The Hamilton Anxiety Rating Scale does not provide standardized assessment questions. However, the inter-rater reliability levels reported for this measure appear acceptable. It is measured using a 5-point Likert scale ranging from 0 (none) to 4 (severe), with the total score ranging from 0 to 56; where <17 indicates mild pain And 18-24 indicates mild to moderate pain. , 25-30 indicates moderate to severe.

4. Perceived Stress Scale (PSS-S)

The Perceived Stress Scale, developed by Sheldon Cohen (1988), is the most widely used tool to measure stress. It measures which situations in a person's life are considered Stressful. These items were designed to understand how participants perceived their lives as unpredictable, unmanageable, and overloaded. The scale also includes some direct questions about current stress levels. The PSS is designed for use with community samples with at least a high school education. The product is easy to understand and the response options are easy to use. Additionally, the questions are general and therefore not specific to any subpopulation. The questions on the PSS ask about thoughts and feelings over the past month. In each case, participants were asked how they felt about a method. It is obtained

from repeated responses (i.e., 0 = 4), 1 = 3, 2 = 2, 3 = 1, and 4 = 0) for the four positive items (items 4, 5, 7, and 8). All items listed are then added together. The 4-item short scale will be created from questions 2, 4, 5 and 10 of the 10-item PSS scale.

5. Beck depression inventory (BDI)

The Becks Depression Scale, developed by Aaron T. Becks, Ph.D. (1987), is a 21-item questionnaire used to measure the severity of depression. The Beck Depression Inventory is copyrighted by The Psychology Company. BDI is a 21-item self-report inventory that measures personality and depressive symptoms (Beck et al. 1961).Beck Depression Inventory, computerized forms, cards (May, Urquhart, Tarran, 1969, cited in Groth-Marnat, 1990); Launch of BDI-11 (see Steer, Rissmiller & Beck, 2000 for information on clinical use of BDI-11). The BDI is a self-administered 21-item self-report scale that measures the prevalence of depression. Although users must have a reading age between fifth and sixth grade to understand the questions, the BDI takes only a few minutes to complete (Groth-Marnat, 1990). The new version of the Beck Depression Inventory is currently the most popular depression assessment tool and takes only 5 minutes to complete. It is important equipment for examination and diagnosis, and is also widely used to monitor treatment. 21-item assessment of depression in clinical and normal subjects. Each item is a list of four statements about specific symptoms of depression, arranged in order of severity. The Beck Scale was< b> developed and validated to assist in patient assessment with reliability and validity. Test results can be the first step in effectively identifying and treating the disease. The Beck Scale can help identify patients who are depressed, anxious, or suicidal.

7.0 Analysis of data

The data will be collected from an outpatient clinic or outpatient clinic at Sadar Hospital in Ranchi. The data will then be analyzed using different methods based on independent t-test to evaluate the difference between various variables in the population and quality of correlation analysis will be used to determine the relationship between success and freedom. Demographic analysis and description of each variable was performed by calculation of means and analysis of variance. Statistical analysis will be done with the help of Statistics

Statistical Package- 20 (SPSS-20). Appropriate statistics will be used to analyze the data and statistical data will be used to test the hypotheses of the study.

8.0 Significance of the study

This study will provide an understanding of stress, anxiety and depression in various periods and will also relate to sleep and health, bad relationships, communication, divorce and marital happiness. This study provides information about the prevention of psychopathology in men and women and the effects of abortion**.**

9.0. It's relevance to the present-day problem and need of the society

In this study, information will be given about pregnancy, which causes physical and psychological harm to male, female and their families. Therefore, this study focuses on research on reducing the relationship between interpersonal relationships, attachment communication, and divorce and stress, anxiety, and depression.

10.0. Contributions to existing knowledge

The findings of the present study would be beneficial for the professionals, clinicians, researchers and academicians in the field of mental health and society as well.

11. Future work

A Similar study could be conducted with a large number of sample sizes.

Chapterization

There will be following five chapters in the research report of the proposed research.

Chapter 1. Introduction

Chapter 2. Review of Literature

Chapter 3. Methodology

Chapter 4. Analysis of Data

Chapter 5. Summary and conclusion

NOTE: This synopsis is tentative, which may be modified depending upon the availability of cases, tools and other situations

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